Van Wert Health

Charity Care and Financial Assistance Policy

Purpose

Consistent with Van Wert Health's mission, Van Wert Health strives to ensure that the financial capacity of any person in need of health care services does not prevent the person from seeking or receiving care. Van Wert Health will provide, without discrimination, care of Emergency medical conditions to individuals regardless of their race, creed, ability to pay, or eligibility for financial assistance or government assistance.

This policy serves to establish and ensure procedures for the review and completion of requests for charity medical care including (i) eligibility criteria for financial assistance – both free and discounted care; (ii) the basis for calculating amounts charged to patients eligible for financial assistance under this policy; and (iii) the financial assistance application process.

Definitions

Medically Necessary Care – Those services reasonable and necessary to diagnose and provide preventative, palliative, curative or restorative treatment for physical or mental conditions in accordance with professionally recognized standards of health care, generally accepted at the time services are provided and are considered medically necessary by the Medicare and Medicaid services.

Uninsured Patients – Individuals who do not have governmental or private health insurance or whose benefits have been exhausted.

Federal Poverty Guidelines (FPG) – Published each year by the Department of Health and Human Services and in affect at the date of service for awards of financial assistance under this Policy.

Patient Friendly Billing – Guidelines outlined by the Healthcare Financial Management Association (HFMA) that promotes clear, concise and correct patient-friendly financial communication.

Program Administration – Department within Van Wert Health's Patient Financial Services area that processes financial assistance applications and makes determinations based upon individual program guidelines.

Amounts Generally Billed (AGB) – Van Wert Health will apply the "look-back method" for determining Amounts Generally Billed. In particular, Van Wert Health will determine the Amounts Generally Billed for emergency or other medically necessary care by multiplying the Gross Charges for that care by the AGB Percentage.

AGB Percentage – Van Wert Health will calculate the AGB Percentage at least annually by dividing the sum of all claims that have been paid in full for emergency and other medically necessary care by look-back together as the primary payer(s) of these claims during a prior twelve (12)-month period by the sum

of the associated Gross Charges for those claims. For these purposes, Van Wert Health will include in ‘‘all claims that have been paid in full’’ both the portions of the claims paid by Medicare or the private insurer and the associated portions of the claims paid by insured individuals in the form of co- insurance, copayments or deductibles.